DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

COSTA RICA

INNOVATION LOAN FOR HEALTH SECTOR DEVELOPMENT

(CR-0144)

LOAN PROPOSAL

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ANNEXES

BASIC SOCIOECONOMIC DATA

For basic socioeconomic data, including public debt information, please refer to the following address:

English:
http://www.iadb.org/RES/index.cfm?fuseaction=externallinks.countrydata

Spanish:
http://www.iadb.org/RES/index.cfm?fuseaction=externallinks.countrydata

ABBREVIATIONS

ARL	Áreas Rectoras Locales [Local Stewardship Areas]
AS	Áreas de Salud [Health Areas]
AYA	Costa Rican Water and Sewage Institute
CCSS	Costa Rican Social Security Fund
COF/CCR	Country Office in Costa Rica
DRS	Regional Health Directorate
EBAIS	Comprehensive Health Care Team
GCR	Government of Costa Rica
IDB	Inter-American Development Bank
INEC	Instituto Nacional de Estadística [National Statistics and Census Institute]
ISC	Inspection, supervision and control
LGS	Ley General de Salud [Health Act]
MS	Ministry of Health
OC	Ordinary Capital
PASP	Plan de Atención en Salud a las Personas [Individual Health Care Plan]
PDP	Plan de Desempeño del Programa [Program Performance Plan]
PEP	Program Execution Plan
PI	Innovation Loan
PPMR	Project Performance Monitoring Report
PND	National Development Plan
PSF	Operational Health Permit
WB	World Bank

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Costa Rica

Tentative Lending Program

2003

Project Number	Project Name	IDB US$ Millions	Status
CR0144	Health Sector Development	10.0	
CR0140	Sector Program for Competitiveness Reforms	100.0	
*CR0143	San Jose-Caldera Toll Road	64.2	
	Total - A : 3 Projects	**174.2**	
CR0148	Rural Roads Program	50.0	
CR0153	Science and Technology Program	50.0	
CR0154	National Congress Modernization	20.0	
CR0155	Program to Strengthen E-govenment in the Fiscal Area	25.0	
CR0145	Urban Poverty Reduction	50.0	
	Total - B : 5 Projects	**195.0**	
	TOTAL 2003 : 8 Projects	**369.2**	

2004

Project Number	Project Name	IDB US$ Millions	Status
CR0147	Secondary and Rural Education	30.0	
CR0149	Investment Program for the Empresa Servicios Públicos de Heredia - ESPH	30.0	
CR0150	Binational Sixaola River Basin	10.0	
CR0151	Municipal Strengthening and Descent	10.0	
CR0152	Procurement and Contractual Services Mo	5.0	
	Total - A : 5 Projects	**85.0**	
	TOTAL - 2004 : 5 Projects	**85.0**	
	Total Private Sector 2003 - 2004	**64.2**	
	Total Regular Program 2003 - 2004	**390.0**	

*** Private Sector Project**

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COSTA RICA

IDB LOANS

APPROVED AS OF NOVEMBER 30, 2002

	US$Thousand	*Percent*
TOTAL APPROVED	***2,169,333***	
DISBURSED	*1,778,759*	*82.0%*
UNDISBURSED BALANCE	*390,574*	*18.0%*
CANCELLATIONS	*219,174*	*10.1%*
PRINCIPAL COLLECTED	*978,021*	*45.1%*
APPROVED BY FUND		
ORDINARY CAPITAL	*1,678,244*	*77.4%*
FUND FOR SPECIAL OPERATIONS	*351,828*	*16.2%*
OTHER FUNDS	*139,261*	*6.4%*
OUSTANDING DEBT BALANCE	***800,738***	
ORDINARY CAPITAL	*685,524*	*85.6%*
FUND FOR SPECIAL OPERATIONS	*114,231*	*14.3%*
OTHER FUNDS	*983*	*0.1%*
APPROVED BY SECTOR		
AGRICULTURE AND FISHERY	*279,662*	*12.9%*
INDUSTRY, TOURISM, SCIENCE &TECHNOLOGY	*109,802*	*5.1%*
ENERGY	*978,886*	*45.1%*
TRANSPORTATION AND COMMUNICATIONS	*109,132*	*5.0%*
EDUCATION	*107,813*	*5.0%*
HEALTH AND SANITATION	*158,802*	*7.3%*
ENVIRONMENT	*0*	*0.0%*
URBAN DEVELOPMENT	*27,966*	*1.3%*
SOCIAL INVESTMENT AND MICROENTERPRISE	*4,392*	*0.2%*
REFORM &PUBLIC SECTOR MODERNIZATION	*283,058*	*13.0%*
EXPORT FINANCING	*98,100*	*4.5%*
PREINVESTMENT AND OTHER	*11,720*	*0.5%*

**** Net of cancellations with monetary adjustments and export financing loan collections***

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COSTA RICA

STATUS OF LOANS IN EXECUTION AS OF NOVEMBER 30, 2002

(Amounts in US$ thousands)

APPROVAL PERIOD	NUMBER OF PROJECTS	AMOUNT APPROVED *	AMOUNT DISBURSED	% DISBURSED
REGULAR PROGRAM				
Before 1996	7	425,729	204,483	48.03%
1996 - 1997	2	40,650	14,400	35.42%
2000 - 2001	4	128,641	17	0.01%
2002	1	14,400	0	0.00%
TOTAL	**14**	**$609,419**	**$218,900**	**35.92%**

INNOVATION LOAN FOR HEALTH SECTOR DEVELOPMENT

(CR-0144)

EXECUTIVE SUMMARY

Borrower:	Republic of Costa Rica	
Executing agency:	1. Ministry of Health (MS) 2. Costa Rican Social Security Fund (CCSS)	
Amount and source:	IDB (OC): Local: Total:	US$6,355,000 US$1,718,000 US$8,073,000
Terms and conditions:	Amortization period: Grace period: Disbursement period: Interest rate: Inspection and supervision: Credit fee: Currency:	25 years 36 months 30 months (six additional months to allow for final evaluation) variable 1% 0.75% dollars of the United States under the Single Currency Facility

Objectives: The ultimate objective of the program is to reduce the global burden of disease and disability caused by risk factors associated with unhealthy eating and behavior. Over the medium term, the program will strengthen the strategic and operational capacity of the MS to achieve nationwide coverage for its efforts to regulate, inspect, supervise and control health risk factors. In the case of CCSS, the program will contribute over the medium term to strengthening its institutional capacities to reform its health-care model, with special emphasis on incorporating health promotion services into the model.

The specific objectives of the program are to: (i) strengthen the institutional capacities of the MS in exercise of its stewardship role; and (ii) develop the institutional capacities of the CCSS to design, test and evaluate a pilot program of health promotion.

Description: The program will be conducted in the country's 32 poorest cantons, including the four cantons that are home to nearly 100 percent of the country's indigenous population. It consists of two components.

1. **Institutional strengthening of the MS for exercise of its stewardship function** (US$5,181,000). The objective of this component is to develop new institutional capacities in the MS, through two specific subcomponents: (i) a pilot program for steering in the health sector; and (ii) a pilot program for regulating the quality of food, drinking water and health care establishments where the complexity of the health risk is medium to low.

   The aggregate outcomes expected from this component include: (i) 32 Local Stewardship Areas (ARLs) conducting inspection, supervision and control (ISC) activities on food and water for human consumption, and on health care establishments, with special attention to those using ionizing radiation equipment, by the end of the project execution period; (ii) methodologies for risk and critical control points analysis introduced and evaluated, with consolidated lessons learned, by program completion; (iii) four public health policy instruments for priority-setting, financing and health spending developed, published and disseminated by the end of the first year of execution; (iv) legal provisions on the stewardship function updated by program completion; and (v) draft reforms to the Health Act submitted to the Legislative Assembly by the Executive Branch, by program completion.

2. **Institutional strengthening of the CCSS for health promotion** (US$1,963,000). The objective of this component is to develop institutional capacities in the CCSS through two subcomponents to be conducted in the 32 cantons targeted: (i) a pilot program for health promotion; and (ii) a pilot program of incentives for innovation in health promotion. The priority target groups will be women, children, the elderly and indigenous groups.

   The aggregate outcomes expected from this component include: (i) at least 100 pilot projects for health promotion executed and evaluated by program completion; (ii) at least 350,000 CCSS affiliates have acquired measurable knowledge, attitudes and behavior conducive to health, by program completion; (iii) at least 10 pilot projects for health promotion designed, executed and evaluated through strategic partnerships with community organizations, municipalities and/or the private sector; (iv) the Individual Health-care Plan updated so that its health promotion goals and indicators reflect the lessons learned from the proposed program; and (v) technical standards updated for the execution and supervision of health promotion programs.

The Bank's country and sector strategy:

The current Bank strategy with Costa Rica (GN-1982-3 of 2 May 2000) calls for supporting government efforts to achieve sustainable growth with equity, by focusing on the factors of production—capital and labor—and their productivity. For the emerging strategy now under preparation, one of the critical vectors is enhancing the efficiency of social spending.

The National Development Plan (PND), presented by the President of Costa Rica on 31 October 2002, has poverty reduction as its central theme. In the health sector, the PND establishes priorities both for the MS and the CCSS. For the MS, the strategic priorities relate to modernizing its capacities to exercise stewardship and steering in the sector, with special emphasis on regulating the services provided by health care establishments and similar institutions. For the CCSS, the overall development goal is to achieve universal health care, with special emphasis on strengthening the promotion of healthy lifestyles.

Consequently, the proposed program is consistent with the Bank's strategy with the country, since it will finance activities designed to improve the quality of social spending while fostering the accumulation of human capital.

Coordination with other official development institutions:

The World Bank has supported health reforms through two programs. The first, which was completed in 2000, was for institutional modernization of the CCSS for assuming the health care provider function. The second, approved in 2001 in the amount of US$17 million, is designed to implement financial and organizational reforms in CCSS hospital services. During the design phase, the IDB project team coordinated the preparation of the proposed program with the executing unit for the World Bank project. The proposed program will complement the World Bank's efforts by concentrating financing on institutional development for the stewardship function of the MS and on the provision of health promotion services by the CCSS.

Environmental and social review:

The CESI considered the profile of this operation on 4 October 2002 and made recommendations that were incorporated into this document. The changes were reviewed by CESI on 22 November 2002. The program will have no direct environmental impact.

Benefits:

The state of health and well being of Costa Ricans will benefit from the program through: (i) a reduction in the global burden of disease due to contaminated water and poor sanitary conditions in the handling of food; (ii) development of a culture for reducing and controlling environmental and consumption risks, based on the provision of public information; and (iii) improved competitiveness of the food supply sector, to the benefit of the tourism and hotel industry.

In terms of health promotion, benefits will accrue through the development of healthy habits and behavior in a portion of the country's poorest and most vulnerable population. The program will have a major positive impact on the health of poor women and indigenous groups in Costa Rica. The number of direct beneficiaries of the program is estimated at 350,000, while indirect beneficiaries will amount to some 1.2 million (including about 50,000 indigenous people) in the 32 cantons assigned priority on the basis of the incidence and concentration of poverty. The direct beneficiaries will be those who participate in the education activities under component 2.

Risks:

One risk for program execution lies in the possible resistance to introduction of a regulatory system on the part of public and private health care providers. To reduce this risk, the program includes funding for information and training for the economic agents that will be covered by inspection, supervision and control (ISC).

Another factor that could delay program execution has to do with the time-consuming procurement procedures in Costa Rica. To address this risk, the Bank worked with the executing agencies during program design to develop a number of execution and performance plans for scheduling the procurement of goods and awarding of contracts for services, identifying in advance the type of procurement that will be required and establishing realistic execution time frames. On this basis, the activities included in the program are those with the greatest likelihood of being executed within the established time frames.

Recognition of expenses:

Authorization is requested to charge up to US$50,000 to the local contribution in recognition of expenses incurred within 18 months prior to approval of the loan, but subsequent to 21 June 2002 for technical assistance activities for early startup of operations, as described in paragraph 3.18.

Special contractual clauses:

As a condition precedent to the first disbursement of component 2, an agreement must be entered into between the Ministry of Finance and the CCSS establishing that the CCSS assumes the executing agency’s obligations under Component 2 and stipulating the conditions for transfer of the resources.

	Prior to distribution of the loan document, the regulations governing the Ministry of Health must have entered into force.
Poverty-targeting and social sector classification:	This operation qualifies as a social equity-enhancing project, as described in the key objectives for Bank activity set forth in the report on the Eighth General Increase in Resources (document AB-1704). This operation also qualifies as a poverty-targeted investment (PTI) (see paragraph 4.11).
Exceptions to Bank policy:	None
Procurement:	International competitive bidding will be required for the procurement of goods and related services exceeding US$250,000, and consulting services exceeding US$200,000. The Bank financing will not be used for the awarding of constructions contracts.

I. FRAME OF REFERENCE

A. Socioeconomic framework

1.1 Costa Rica made significant economic and social progress during the 1990s, as reflected in: (i) a growth rate higher than that of preceding decades, and above the average for Latin America and the Caribbean; (ii) a more open and internationalized economy thanks to the production and export of modern manufactures and services; (iii) increasing levels of foreign investment, particularly in high-technology; and (iv) the best health status in the region, comparable in many aspects to that of industrialized countries.

1.2 Nevertheless, the beginning of the present decade was marked by a slowdown in growth, persistently high levels of unemployment, and a situation in which 20 percent of households were living in poverty. While social spending per capita maintained a rising trend during the period 1990-2001, the poverty situation has remained stable, and the fruits of economic growth have been increasingly concentrated among the higher-income quintiles.

1.3 The National Statistics and Census Institute (INEC) has classified the country's 84 cantons against an index of unmet basic needs. The most critical needs are to be found in 32 of those cantons (Table I.1). Poverty in Costa Rica is most severe in the country's indigenous reserves, in the frontier zones and urban shantytowns, and along the coasts, particularly in rural areas. The main determinants of poverty in Costa Rica have to do with low education levels, households headed by females, and old age.

Table I.1
Cantons with the most critical needs

Los Chiles	Buenos Aires*	Talamanca*	Cartago
Upala	La Cruz	Osa	Goicochea
Sarapiquí	Golfito	Guatuso*	Turrialba*
Matina	Nandayure	Turrubares	San Ramón
Parrita	Limón	Guácimo	Alajuelita
Pococí	Coto Brus	Acosta	
Hojancha	Corredores	Nicoya	
Siquirres	León Cortés	San José	
Alajuela	Desamparados	Puntarenas	(*) Indigenous populations

Source: National Development Plan (PND)

B. The demographic and health profile

1.4 In the early 1970s, Costa Rican began a process of demographic and epidemiological transition, characterized by a decline in fertility, an increase in life

expectancy, and a sharp drop in the contribution of infectious diseases to overall mortality, to a level of less than 10 percent in 1978. Today, the infant mortality rate is 10 per 1000 live births, and life expectancy is 77.6 years. This performance has given Costa Rica a health profile similar to that of the countries of Central Europe and certain Latin American countries such as Chile and Cuba. Apart from the characteristics mentioned above, the disease profile of the countries is characterized by increasing mortality from diseases of the circulatory system.

1.5 An analysis of the principal causes of death (mortality) and of non-fatal diseases (morbidity) indicates that the three major causes of general mortality are: (i) diseases of the circulatory system; (ii) tumors; and (iii) lesions and injuries. Diseases of the circulatory system are the principal cause of overall mortality in Costa Rica: they represent the second-greatest cause of death for both sexes after 30 years of age, and the primary cause of death for both sexes after 60 years of age. Nearly 50 percent of deaths are due to ischemic heart disease (57 percent of deaths are due to acute myocardial infarction, particularly among men). The second-ranking cause of mortality among this group is represented by cerebral-vascular diseases, from which the probability of death is greater among women than among men. Finally, hypertension ranks third, among both men and women.

1.6 Tumors are the second-ranking cause of general mortality among all age groups, and for both sexes. For women between the ages of 30 and 50, tumors are the principal cause of death. The most frequent tumors among women are, in order of prevalence, gastric cancer, breast cancer, and cervical cancer. Among men, the three most prevalent tumors are gastric cancer, lung cancer, and prostate cancer. Lung cancer is the fourth most prevalent tumor among women, with an incidence that represents one-half the rate of new cases among men.

1.7 Finally, lesions and trauma are the leading cause of death among females between 5 and 30 years, and among males between 1 and 50 years. The most important external causes of death between 1990 and 1997 were, in descending order: (i) small motor vehicle traffic accidents (14.2 per 100,000 residents); (ii) homicide and assault and battery (5.38 per 100,000); (iii) accidental falls (5.38 per 100,000); and (iv) suicides and self-inflicted injuries (5.13 per 100,000).

1.8 In terms of non-fatal illnesses that result in disability and a lower quality of life, the most important are endocrine diseases such as diabetes mellitus, those of the liver such as cirrhosis, and those of the respiratory tract. Sixty percent of the latter illnesses represent chronic diseases of the respiratory passageways, the most important of which is chronic obstructive pulmonary disease; as with lung cancer, this is clearly linked to tobacco use.

1.9 The epidemiological profile described above is typical of countries where the relative importance of biological and infectious causes of disease has declined, and the determinants of health have changed. In contrast to biological determinants such

as infectious agents, this profile is determined by individual behavior and by environmental and consumption factors. Table I.2 lists the environmental and consumption-related habits and risk factors that contribute to the country's current epidemiological profile, pointing in particular to: (i) improper eating habits; (ii) lack of physical exercise; and (iii) the rising trend in consumption of tobacco, alcohol and other addictive substances.

Table I.2
Risk factors contributing to the epidemiological profile in Costa Rica

Risk factor	Current situation
Improper eating habits	Low consumption of fiber and rising consumption of total fat. Excessive cholesterol levels in 10 percent of the population between 20 and 59 years. Obesity, primarily among women (up to 70 percent in women over 45 years)
Lack of physical exercise	Fifty-three percent of the population between 12 and 70 years never exercises. High self-reported stress levels (75 percent of those reporting stress were among those who exercise least).
Consumption of tobacco, alcohol and other addictive substances	The rate of tobacco use among the population aged 12 to 70 rose from 14 to 22 per 1,000 between 1990 and 1995. Average starting age was 16 years. More than 50 percent of the tobacco-dependent population practices no physical exercise.

Source: Ministry of Health (MS) and Costa Rican Social Security Fund (CCSS)

C. The health sector

1. Basic structure

1.10 The principal institutional players in the health sector are the Ministry of Health (MS), the Costa Rican Social Security Fund (CCSS) and the Costa Rican Water and Sewage Institute (AYA). From 1993 to 2000, public spending on health maintained an upward track, although the average annual increase never exceeded 1.8 percent over that period. The CCSS accounted for 76 percent of total spending, the AYA for 9 percent, the MS for 8 percent, and other entities that are included within the legal definition of the health sector (the National Insurance Institute and the University of Costa Rica) for the remaining 7 percent. During the 1990s, spending by the MS declined, while outlays by the CCSS rose as a result of newly introduced reforms to the sector.

1.11 These institutional reforms, which began during the 1990s, assigned separate, specialized and complementary functions and responsibilities to the MS and the CCSS. With the support of the Bank, responsibility for the delivery of health care services was transferred from the MS to the CCSS. In this way, the "stewardship

function" was separated from the "provider function", the first being assigned to the MS and the second to the CCSS. The reforms also led to changes in the CCSS health care model, through: (i) the creation of the Basic Comprehensive Healthcare Teams (EBAIS); (ii) the institution of greater autonomy and social control in the network of hospital care providers; and (iii) negotiation of performance contracts between the CCSS and its own institutional network, whereby the CCSS headquarters signs performance contracts defining the provider's responsibilities, the expected results, and the resources earmarked for achieving the social objective of the contract.

1.12 The organizational structure of the MS consists of the central area and two decentralized areas: (i) the nine Regional Health Directorates (DRS); and (ii) the Local Stewardship Areas (ARL) for each of the 84 cantons into which the country is divided for administration purposes. The CCSS has a central or corporate office, and a decentralized area consisting of the network of hospitals (13 peripheral hospitals and 5 specialized national hospitals), 10 specialized clinics, and 93 health areas covering the roughly 700 EBAIS operating around the country. The typical EBAIS structure includes a physician, a nurse and a public health worker, each of whom serves on average 3,500 people through five programs of integral care focused on children, adolescents, women, adults and the elderly.

1.13 Costa Rica has a private health sector with its own network of medical establishments. Since 1998, the CCSS has been contracting for medical services with "Medical Cooperatives." The results of this program have been so successful that, by the end of 2001, the four existing cooperatives were serving some 400,000 CCSS affiliated members.

2. Institutional aspects

1.14 The institutional framework for the health sector consists of: (i) a set of legal and legal standards; (ii) the procedures by which the MS and the CCSS fulfill their mandates; and (iii) the technical, managerial and computerized information capacities of these two entities for carrying out their specialized functions.

1.15 The principal policy instruments underlying the stewardship of the MS are the 1973 Health Act (LGS) and its regulations. In 1983, Executive Decree 14313 formally created the health sector; the National Health Sector Council was created in 1998 (decree 27446-5); Law 7927 of 1999 reformed the by-laws of the MS; and Law 8239 on the Rights and Duties of Users of Public and Private Health Care Services was approved in April 2002. In December 2002, the regulations governing the MS were approved. These legal instruments form the basis of health policy in Costa Rica and allow the MS to exercise stewardship and steering functions in the sector. Among other things, the MS is empowered to: (i) formulate health policies; (ii) exercise inspection, supervision and control (ISC) over the environmental and consumption risk factors that affect public health; and (iii) establish sanitary

regulations and technical requirements for providers of medical and hospital services.

1.16 The major legal provisions governing operation and functioning of the CCSS are: (i) the CCSS Act, issued in 1943; (ii) the Hospital Decentralization Law of 1998; and (iii) the Regulations Governing Health Boards. The Decentralization Law introduced three basic institutional reforms: it equipped the decentralized bodies of the CCSS with their own legal personality, it created Health Boards for strategic management of health establishments; and it placed management undertakings on a true contractual basis.

D. The institutional challenges facing the MS

1.17 Despite the scope of its legal mandate, the MS has shown a weak institutional capacity for exercising stewardship over the last decade. Most of the functions, infrastructure and human resources (more than 1,900 employees) that the MS had for providing health care services were transferred to the CCSS during the 1990s. Since the end of the 1990s, the MS has been transforming its organizational structure so as to focus on the stewardship function. As a first step, it transformed its organizational structure and the duties and responsibilities of its personnel.

1.18 Subsequently, Law 7927 amended the MS Act, but it was not followed by any regulations governing the responsibilities and jurisdiction of the MS, particularly as they relate to the decentralized levels. The lack of such regulations has created ambiguities in the definition of jurisdiction and resources among the organizational levels of the MS, and the benefits expected from the organizational restructuring of the late 1990s have not materialized. Prior to distribution of this document, the Executive Decree regulating the MS Act establishing the jurisdiction and responsibilities of the MS in deconcentrated operations at both the central level and at the level of the agencies reporting to it and deconcentrated agencies entered into force.

1.19 A further source of institutional constraints of a legal nature facing the MS is the relative obsolescence of the LGS. When it was conceived in 1973, the LGS envisioned an institutional, political and health environment that was quite different from the current situation in the country. The principal factor constraining exercise of the stewardship function is the lack of enforcement authority for the MS, even in the face of serious violations or situations that pose a threat to public welfare. Among other weaknesses, the main shortcoming in the enforcement authority of the LGS is that all violations are treated as minor infractions.

1. Challenges in steering the health sector

1.20 Steering the health sector refers essentially to the procedures by which the MS provides technical guidance and exerts social influence within and beyond the

health sector. As the current government sees it, the principal challenges in steering the sector relate to: (i) inadequate technical capacities to define public health expenditure priorities for the country; and (ii) inadequate policy formulation by other public bodies whose acts or omissions can affect the functioning of the health sector.

1.21 Currently there is inadequate institutional capacity to influence the formulation of public policies that impact on the health sector. For example, when it comes to establishing health expenditure priorities for the CCSS and other institutional and private players, the MS has no system for monitoring the sources, uses and beneficiaries of public or private health expenditure.[1] With the support of the Bank, the Central Bank and INEC have recently launched an initiative to improve the quality of national income and expenditure surveys and to strengthen the system of national accounts in ways that would allow the MS to work with these agencies to prepare a system of national health accounts.

1.22 The MS also lacks policy tools for prospective analysis of premature and predictable mortality and disability, and it has no means for monitoring the overall degree of equity in the provision of health care, which makes it impossible to estimate the economic and social impact of the current health and disease profile or to target spending on excluded and vulnerable groups such as indigenous people, migrants and transient populations.

1.23 The past decade has witnessed the disorderly growth of medical training centers. In fact, the burgeoning supply of trained medical personnel is beginning to create a surplus, and yet the MS has no models for forecasting the supply of and demand for health professionals that could be used to establish informed dialogue with training institutions, the professional associations and the country's principal health employer, the CCSS.

1.24 Apart from challenges of generating empirical evidence of practical use in policy making, the MS has little experience in designing and implementing advocacy and public information strategies necessary for disseminating information, generating coalitions of opinion and seeking consensus in ways that would give it measurable results on the health sector's performance.

2. Challenges for exercising stewardship

1.25 The formal rules under which the MS exercises its mandate to protect public health are based essentially on the 1973 LGS and its regulations, and are exercised essentially through the issuance or cancellation of Operational Health Permits

[1] Available information indicates that average health expenditure per capita is US$48. Nevertheless, available information sources offer no data for estimating private expenditure on medical services, drugs or supplementary health insurance.

(PSFs). In fact, the PSFs are the basic instrument whereby the MS can intervene with respect to the risk factors that affect the human environment, particularly in fields such as food and water quality and the regulation of health care establishments. It is this intervention capacity that allows the MS to promote, prevent or mitigate the impact that various risk factors can have on public health. Under existing legislation, the Human Environment Protection Directorate of the MS sets the rules of the game for granting or revoking the PSF, while the Health Care Services Directorate is responsible for authorizing and accrediting health care establishments. The Regional Directorates are responsible for monitoring the roles of the ARL as it relates to inspecting economic and social players subject to regulation.[2]

1.26 The country's growing urbanization and the expansion of tourism have brought significant changes to traditional consumption habits, and people are increasingly taking their meals away from home. This means that there has been significant growth in the number and variety of risk factors affecting the human environment, especially in places where the government's intervention capacity has traditionally been limited. For this reason, the current government's health policy places great importance on decentralizing operations to the ARL, particularly when it comes to risks associated with food and water consumption and the supervision of health care establishments, where special emphasis is placed on risks from ionizing radiation.

1.27 The institutional assessment performed by the Bank revealed problems at the central level of the MS as well as at its decentralized levels. The central level, which was traditionally concerned with operational functions, faces a number of challenges, including: (i) formulating technical standards; (ii) developing and institutionalizing modern systems for monitoring and evaluating regulatory enforcement; (iii) inter-sectoral coordination with other public institutions that have complementary responsibilities (Public Safety, Environment, Agriculture, Industry and Commerce, CCSS, AYA, Tourism and Municipalities, among others); (iv) steering public information, dialogue and generating consensus among economic and social players that are subject to or beneficiaries of regulatory, inspection, supervision and control services; and (v) financial sustainability of ISC services.

1.28 At the decentralized level, the ARL lack the physical resources and the technical instruments for effective and efficient conduct of ISC. In fact, the establishments housing the ARL beneficiaries of the program were for the most part health centers or personal care centers which, with the shift in the role of the MS, were converted into municipal health centers, from which the stewardship function is to be

[2] The Government of Costa Rica has for several years been taking steps to simplify public procedures: in the case of operating permits, these moves resulted in the elimination of all permits granted by other public entities, with the exception of the Operational Health Permit (PSF) and the operating license issued by municipalities, which however can only be granted once a PSF has been issued.

exercised. The MS recently undertook an evaluation of the physical status and equipment of the ARL and has identified problems with maintenance of the physical plant. In institutional terms, moreover, the evaluation has identified three kinds of challenges to the decentralized exercise of the stewardship function: (i) the methodologies and the minimum equipment required for the ISC; (ii) training of human resources in priority management areas; and (iii) shortcomings in information processing resources for the ISC.

3. The technical and technological challenges

1.29 In the food sector, food safety regulations in the country are based on physical inspection of the production, distribution and handling of food, in order to determine environmental or health risks. In this type of inspection, all subjects of inspection and supervision are treated equally, without regard to differences of probability in health risks from different sources. Moreover, the inspectors have no objective standards for systematically and objectively assessing the risks and identifying critical control points.

1.30 In the water sector, the MS is responsible for the quality of water for human consumption. The institutional evaluation indicates that efforts to decentralize this function are facing challenges relating to: (i) adaptation of inspection and supervision methodologies to an approach that focuses on risks and critical points; and (ii) inadequate technical capacities on the part of ARL operating staff.

1.31 When it comes to supervision and control over health care establishments, licensing lies with the MS. The country's existing establishments have been divided into three categories on the basis of risk criteria. Those with the greatest risk include technologically highly complex hospitals, licensing of which is underway with funding from a World Bank loan. There are, however, establishments of medium complexity, such as peripheral or general hospitals, and low-complexity establishments, such as doctors' and dentists' offices, EBAIS and hospices, where licensing has not yet begun although the legal basis exists.

1.32 The ISC of these establishments also requires the availability and use of simple technologies for making rapid field measurements, for example, of fecal contamination of water, residual chlorine, noise pollution or ionizing radiation.

4. Human resources

1.33 In terms of human resources, the evaluation suggests that the effort to decentralize ISC functions will encounter problems both within and beyond the MS. Within the MS, the major problems identified relate to the limited knowledge and skills of employees of the DRS and the ARL for performing ISC functions that were previously handled centrally by the MS. Outside the MS, the problems relate to the low level of training among people handling food in establishments that cater to the

public, and the fact that health care establishments have little information on biosafety standards, particularly those concerning ionizing radiation.[3]

5. Computerization challenges

1.34 In terms of computer resources, the MS currently has two information tools that were designed to support issuance of the PSFs at the central level and to simplify procedures for users of the health regulation system. These tools have been in place at the central level for three years, but they have not yet been transferred to the decentralized levels. Moreover, they exhibit some technical problems: (i) the technological platform used is obsolete; (ii) the MS does not have the source programs; and (iii) the 10 modular components are not well integrated.

1.35 Additional computerization challenges arise in areas where the MS has not yet been engaged, but which will have to be addressed if the stewardship function is to be decentralized. The most important such problems are: (i) lack of consolidated records on each establishment supervised, and possible sources of risk, by level of complexity, type of risk and geographic location; (ii) lack of means for consolidating information on risks or on inspection results, by regions or geographic areas; (iii) no technological means for gathering local data or for conducting standardized assessments of the risks or critical points; and (iv) the current system was not designed to operate in an Internet environment, or to keep integrated, consolidated information in a single, updated, online database.

6. Financial and sustainability challenges

1.36 The issuance and renewal of PSFs constitutes one of the principal sources of funding for health ministries in most countries of the region. Yet until recently the MS did not have the legal capacity to retain revenues from fees, charges or services within its own budget, a situation that discouraged financial self-sufficiency and proper exercise of the stewardship function. In light of the downward trend in public budgetary funding during the 1990s, and a future scenario of fiscal austerity, one of the key factors for success with stewardship will be to secure partial financial independence of the ministry. The MS Act allows the ministry to charge for services and to hold funds in trust. No regulations have been issued, however, for this legal instrument, nor are there any financial projections with respect to sustainability of the stewardship function. Such information would not only allow the MS to plan financially for stewardship, but could also be used for public information campaigns to generate support and recognition of the social value added through production of public goods in the form of inspection, supervision and control services.

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[3] The inventory of ionizing radiation sources in health establishments shows a small number of high-risk devices (specifically linear accelerators and cobalt therapy equipment used for treating cancer) and a wide availability of radiology equipment in public and private hospitals throughout the country.

E. Institutional challenges facing the CCSS

1.37 The financing and organization of health care services in the CCSS has traditionally had a biological focus, centered on the concept of disease as the fundamental element of its responsibilities. This focus is now inadequate for dealing with emerging health problems, since it addresses only the biological consequences of the accumulation of risks, but does nothing to prevent or avoid unhealthy behavior or habits that give rise to those risks.

1.38 As the population of Costa Rica has become increasingly urbanized and cosmopolitan in recent years, profound cultural changes have emerged, particularly among the younger population groups. Habits traditionally associated with rural life are gradually being replaced by new and unhealthy ones (sedentary lifestyle, smoking, alcohol, etc.). Fortunately, these harmful effects can be forestalled if timely action is taken to prevent lifestyle changes from degenerating into unhealthy behavior. The impact of such measures on the financing of the health system are enormous, since most illnesses associated with these risk factors carry a high cost. Changing or adapting the health model, however, is a complex and gradual process that, in the absence of unlimited funding, will only come about in response to the definition of new health investment priorities, together with the appropriate budgetary reallocations.

1.39 In Costa Rica, funding devoted to primary health care increased from 12 percent of the annual CCSS health budget to 22 percent by the end of the 1990s. While this trend is moving in the right direction, the CCSS has no mechanisms for estimating the distribution of this funding among the various services provided at the primary level, which include medical consultations, disease prevention and health promotion activities.

1.40 At the end of the 1990s, the CCSS decided to overhaul the health-care model, for which it prepared the **Individual Health Care Plan** (PASP) setting out health priorities for the period 2001 to 2006. The PASP developed its own methodology for: (i) analyzing the health situation in the country; (ii) identifying priority health problems; and (iii) selecting the 15 most cost-effective interventions for addressing them. A key innovation of the PASP was to define explicitly the results expected from its implementation, and to place considerable importance on epidemiological and economic evidence for identifying priorities and interventions.

1.41 The PASP still faces some challenges: (i) the CCSS has limited capacity to develop and implement the kind of execution monitoring and results evaluation system that a program of this type requires; and (ii) despite the importance that the PASP attaches to health promotion goals, the CCSS lacks the organizational expertise to design and implement interventions of this kind. Of the 15 priority interventions in the PASP, 5 in fact represent interventions that require technical, information and human capacities for providing health promotion services (Table I.3).

Table I.3
Priority interventions requiring health promotion services

PASP interventions	Operational definition
Promoting healthful lifestyles	Promoting and assisting lifestyles involving appropriate physical activity, healthy eating habits, and discouraging consumption of tobacco, alcohol and other drugs, with the emphasis on priority groups
Promoting mental health	Promoting mental health and reducing modifiable behavioral risk factors
Promotion, prevention, control and care for infectious intestinal diseases	Institutional and inter-sectoral efforts to reduce child morbidity and mortality from infectious intestinal diseases
Prevention, promotion and care for diabetes mellitus	Education and assistance on nutrition and physical activity for diabetic patients
Promotion, prevention, detection, care, treatment and timely monitoring of patients with chronic obstructive pulmonary disease	Promotion and education with respect to respiratory health

1.42 As a guide for executing the health promotion activities of the PASP, the CCSS has the Institutional Health Promotion Plan, which was approved by its Governing Council in 1999. That plan develops the various concepts of health promotion in detail, and defines the tools for implementing them, which include: (i) health education; (ii) social marketing; and (iii) social participation. In addition, the plan calls for implementing activities through the Health Areas (and the EBAIS) for the preparation of local health promotion programs which, since 2001, have been included in the performance contracts signed with the CCSS central office.

1.43 Despite the progress achieved, implementing the health promotion proposals at the local level has encountered the following problems: (i) there are no execution or performance plans that would allow progress and achievements to be monitored, and a link to be established between the performance contracts, the generation of concrete health promotion outcomes, and the financing of the Health Areas (AS); (ii) there are no specific budgets for the health promotion programs, nor any specific incentives for executing them; and (iii) there is no cost-effectiveness analysis of the interventions that have been undertaken.

1.44 The evidence in hand suggests that there are a number of underlying problems explaining the situation described above. On one hand, the decentralizing strategy of the CCSS has resulted in the transfer of many of the responsibilities and resources required for implementing the PASP to the Health Areas and in particular to the EBAIS. This decentralization was not accompanied, however, by the development of institutional capacities at the central level for: (i) formulating health promotion strategies for the CCSS; (ii) standardizing, systematizing and validating specific health promotion interventions in response to PASP priorities; and

(iii) monitoring and evaluating implementation and outcomes of local health promotion programs as a means of improving strategies and refining the health-care model.

1.45 The same evidence suggests that, although all the AS have nominal health promotion programs, there is considerable ambiguity in the operational definition of what actually constitutes a cost-effective health promotion intervention. In fact, the prevailing organizational culture and the traditional medical model have meant that in many AS the local team sees health promotion activities as merely an extension of medical consultations. Moreover, fewer than 10 percent of local operating staff of the CCSS have received any training in health promotion techniques and tools.

1.46 Finally, the prevailing approach to health promotion assumes that there are economic and comparative advantages in managing health promotion strategy interventions at the decentralized level. International experience, and indeed the policy of the current CCSS administration, suggests that this may not be the case. In fact, the CCSS would derive economies of scale from insisting on exclusively central management for social marketing programs, where the target population is nationally representative, as well as for campaigns that, because of their magnitude or scale, require partnerships with the private sector or with other public institutions. On the contrary, health education and social participation interventions, where the working unit is the individual, the family or the community, could be conducted at lower unit cost in the AS.

F. The Bank's strategy in the country

1.47 The current Bank strategy for the country (GN-1982-3, 2 May 2000) calls for supporting government efforts to achieve sustainable growth with equity, by focusing on the factors of production—capital and labor—and on the productivity of their use. One of the most important aspects of the strategy is its support for strengthening human capital by improving the efficiency of social expenditure, enhancing the autonomy of social service providers, strengthening the stewardship bodies for social services, and increasing the contribution of human capital to growth. Consequently, the proposed program is consistent with the Bank's strategy in the country, since it will finance activities designed to improve the stewardship function for the health sector and to foster the accumulation of human capital.

1.48 The Bank supported the initial reforms in the health sector through the Health Care Services Improvement Program (Loans 711/OC-CR and 712/OC-CR), which concentrated on financing health infrastructure (the Alajuela hospital and operating infrastructure for 40 EBAIS) and technical assistance for designing stewardship instruments for the MS. During execution of the loan, the MS developed legal instruments for establishing the institutional basis for the sector stewardship function. In addition, it transferred to the CCSS more than 1,900 employees and all of its service provision infrastructure and programs. Currently, 100 percent of the

program resources have been committed, and construction of the Alajuela hospital is nearing completion. Upon completion of program execution, the principal challenges in the future will have to do with the failure to establish stewardship functions at the decentralized offices of the MS, and the acquisition of institutional steering capacities for the sector.

G. Coordination with other official development institutions

1.49 The World Bank has supported CCSS reforms through two programs. The first, which was completed in 2000, was aimed at institutional modernization for assuming the health care provider function. The second, recently approved in the amount of US$17 million, is designed to implement financial and organizational reforms in the CCSS hospital services. During the design phase, the project team coordinated the preparation of this program with the executing unit of the World Bank project. The proposed program will complement the World Bank efforts by concentrating financing on institutional development for the stewardship function of the MS and on the provision of health promotion services by the CCSS.

H. The government's strategy

1.50 The National Development Plan (PND), presented by the President of the Republic on 31 October 2002, has poverty reduction as its central theme, involving five strategic priorities: (i) capacity development; (ii) stimulating economic growth; (iii) public safety and justice; (iv) modernizing the public sector; and (v) harmony with the environment. In the health sector, the PND establishes priorities both for the MS and for the CCSS.

1.51 For the MS, the strategic priorities relate to modernizing its capacities to exercise stewardship and steering in the sector, with special emphasis on regulating the services provided by health establishments and similar institutions, to the development of technical and political mechanisms and instruments, and strengthening the human resources of the MS.

1.52 For the CCSS, the overall development goal is to universalize health care by extending their coverage, in terms both of population and geography, through three specific policies: (i) strengthening the promotion of healthy lifestyles; (ii) strengthening preventive services; and (iii) providing timely and high-quality treatment of diseases.

I. Innovation and learning elements of the program

1.53 Based on the program's objectives and the institutional transformation now occurring in the health sector, the present program will constitute a new phase in the sectoral reform process. The proposed institutional changes will help to consolidate the reforms undertaken in previous years and will serve as a point of departure for subsequent phases of the reform. The Innovation Loan approach has

been selected in recognition of: (i) the importance of demonstrating the future potential of the models applied in the program (the decentralized stewardship model and the health promotion model); (ii) the importance that Costa Rican society places on consensus and a gradual approach to reform; (iii) the importance for the country of having the MS and the CCSS acquire institutional experience and capacities for designing and implementing the policy instruments and strategies supported by the program; and (iv) the need to acquire further technical capacities before the reforms are extended to the entire country.

1.54 There will be measurable lessons to be learned from the program in the short and medium term. In the short term, and within the execution period, the program will generate health policy instruments and empirical evidence that the MS and the CCSS can use to adjust the current standards and technical procedures. Over the medium term, and beyond the execution period, the lessons learned will facilitate the formulation of new legal, social and institutional frameworks for consolidating reforms.

1.55 Because of its nature as an innovative project for learning, the program is not expected to generate measurable impacts on the state of public health in the country. Nevertheless, the experience, evidence and capacities that will be acquired, if extended to the entire country, should have a favorable impact on people's health, in terms of reduced incidences of chronic and degenerative illnesses due to unhealthy consumption habits and behavior.

II. THE PROGRAM

A. Objectives and description

2.1 The ultimate objective of the program is to reduce the global burden of disease and disability caused by unhealthy consumption and behavioral patterns. Over the medium term, the program will strengthen the strategic and operational capacity of the MS to achieve nationwide coverage for its efforts to regulate, inspect, supervise and control health risk factors. In the case of CCSS, the program will contribute over the medium term to strengthening its institutional capacities to reform its health-care model, and in particular to incorporate health promotion services into that model.

2.2 In the short term, the specific objectives of the program are: (i) to develop new institutional capacities in the MS in the exercise of its stewardship role; and (ii) to develop the institutional capacities of the CCSS to design, test and evaluate a pilot program of health promotion. Table II.1 shows the aggregated outcome indicators for program execution.

Table II.1
Aggregated outcome indicators

Component 1	Component 2
32 ARL conducting ISC activities on food and water for human consumption, and on health care establishments of medium and low complexity, with special attention to those using ionizing radiation equipment, by the end of the execution period. Risk and critical control points analysis methodologies introduced and evaluated, with lessons learned, by the end of program execution. Four health policy instruments for the definition of priorities, financing and health expenditure executed, published and disseminated by the end of the first year of execution. Legal standards for exercise of the stewardship function, updated by the end of execution; and Draft reforms to the Health Act submitted to the Legislative Assembly by the Executive Branch, by the end of execution.	At least 100 pilot projects for health promotion executed and evaluated by the end of execution. At least 350,000 CCSS affiliates have acquired measurable knowledge, attitudes and behavior conducive to health, by the end of execution. At least 10 pilot projects for health promotion designed, executed and evaluated through strategic partnerships with community organizations, municipalities or the private sector. Individual Health-care Plan updated so that its health promotion goals and indicators reflect lessons learned from the program; and Technical standards updated for the execution and supervision of health promotion programs.

B. The program structure

2.3 To achieve its objectives, the program has been divided into two complementary but different components: (i) institutional strengthening of the MS for exercise of its stewardship function; and (ii) institutional strengthening of the CCSS for health promotion. Program activities will be executed in the country's 32 poorest cantons, listed in table I.1[4].

1. Component 1: Institutional strengthening of the MS for exercise of its stewardship function (US$5,181,000)

2.4 This component will develop new institutional capacities within the MS, through two specific subcomponents: (i) a pilot program for steering the health sector; and (ii) a pilot program for regulating the quality of food, drinking water and health care establishments of medium and low complexity.

a. Subcomponent 1. Pilot program for steering in the health sector

2.5 This subcomponent is intended to develop technical steering capacities within the MS for setting national priorities in public health spending and for formulating public policies that affect the structure of the health sector. It will finance: (i) a technical assistance program to produce empirical evidence that the MS can use to influence other institutional players; and (ii) development of advocacy and public information capacities to influence policymaking by other government agencies and to shape public opinion.

2.6 In order to generate empirical evidence in support of sector steering, the program will finance technical assistance services for the preparation of four policy instruments: (i) a system for analyzing the global burden of disease; (ii) a system of national health accounts; (iii) a supply and demand model for human resources in the health sector; and (iv) a system for monitoring equity and quality in health care services at the local level. This last aspect will pay particular attention to the health of priority groups in terms of the country's social policy: (i) indigenous peoples, (ii) women, (iii) children, and (iv) the elderly.

2.7 The program will finance specialized technical assistance for applying these policy instruments in the formulation of the country's health policy. The evidence generated in this way will allow the MS to influence the formulation of policies with a specific focus on gender and social inclusion. The program will also finance technical assistance for disseminating the results and producing materials through: (i) consultation workshops in at least 10 of the 32 beneficiaries cantons, including the four cantons with significant indigenous populations; (ii) a national seminar to

[4] Includes 4 cantons that are home to nearly 100 percent of the country's indigenous population: Talamanca, Turrialba, Guatuso and Buenos Aires.

present each of the policy instruments; and (iii) publication of the instruments, over the MS web site and in the form of electronic books.

b. Subcomponent 2. Inspection, supervision and control (ISC)

2.8 The specific objectives are: (i) to strengthen the legal and regulatory framework for exercise of the stewardship function; (ii) to develop central institutional capacities within the MS to design and evaluate systems for ISC of food and water for human consumption as well as health care establishments, of medium and low complexity with special priority to those using ionizing radiation equipment; and (iii) to develop capacities at the decentralized level of the MS for monitoring and implementing ISC of food, drinking water and health care establishments of medium and low complexity.

2.9 **Legal and regulatory framework for the stewardship function**. The program will finance technical assistance for: (i) revision and analysis of the legal and regulatory framework governing the exercise of the stewardship function; (ii) adjusting that framework to reflect the MS competencies; (iii) drafting legislation for reforms to the LGS, with particular priority to the section on sanctions; and (iv) public consultation and information activities, both before and after introduction of the legal and regulatory reforms. In particular, the program will implement and evaluate consultation and information activities geared to the interests and perceptions of social players representative of the program's priority groups: women, children, the elderly and indigenous people.

2.10 **Developing institutional capacities at the central level**. Program activities at the central level of the MS will include: (i) development and validation of new ISC methodologies relating to food and water for human consumption and the licensing of health care establishments of medium and low complexity, with particular priority to those using ionizing radiation equipment; (ii) design and execution of an ISC training program for MS staff at the central level; (iii) design and implementation of an ISC information system on food and water for human consumption and on health care establishments, with particular priority to those using ionizing radiation equipment; (iv) design and execution of a system for monitoring and evaluating decentralized execution of the stewardship function; and (v) construction of a financial model to ensure sustainability of the stewardship function at the decentralized level.

2.11 The program will finance technical assistance for design of an ISC methodology that will allow for validation, implementation and dissemination of ISC standards and methodologies in the beneficiaries cantons. Consultation and dissemination workshops will be held in the 32 beneficiaries ARL and with social and economic players that are ISC subjects/beneficiaries. As well, financing will be provided for: (i) design and execution of a program of training in the health aspects of handling food; and (ii) design and execution of a training program in quality and biological

safety for health care establishments of medium and low complexity, with special priority to ionizing radiation.

2.12 In addition, the MS will design and test a new information system that will allow for local inspection of human health risks in food and water, ionizing radiation and health establishments, and for issuance of the PSF. Specialized technical assistance will be provided to adapt the MS information system so that it can operate in a geographically distributed environment and over the Internet. Based on the ISC methodologies to be developed by the MS, the system's functionality will be validated by means of a pilot test that will involve three of the 32 beneficiary cantons: one of these will be predominantly indigenous, the second rural and the third urban. Based on the pilot evaluation, a procurement and technical support plan will be prepared for introducing the new system in the remaining cantons. To this end, the program will finance (i) procurement of computers, office equipment and PDAs, (ii) purchase of software applications, and (iii) technical support and training services for introducing the system in the 32 ARL.

2.13 In addition, the program will finance specialized consulting services for constructing a financial model to project the costs and revenues associated with extending the decentralized ISC model to the entire national territory, and for recommending mechanisms to the MS for enhancing the financial viability of decentralizing the stewardship function, under various macroeconomic and fiscal scenarios.

2.14 **Institutional strengthening of the MS at the decentralized level**. Financing will be provided for: (i) developing institutional capacities in the regional health directorates and in the local stewardship areas; and (ii) a decentralized ISC pilot program in the 32 beneficiary cantons.

2.15 The program will finance: (i) human resource training for the 32 ARL, in methodologies for authorizing and accrediting food establishments catering to the public and health establishments of medium and low complexity, with particular priority on those using ionizing radiation equipment; (ii) improving the basic layout of the establishments in which the 32 beneficiary ARL operate; (iii) procurement of office equipment and computers for maintaining communication and connectivity with the central level, and basic equipment for the inspection of radioisotopes and drinking water samples; and (iv) specialized laboratory services for the analysis of water quality and food safety.

2.16 For implementing the new ISC methodologies, the program will finance: (i) technical assistance to support the ARL during execution of ISC functions; (ii) technical assistance to the DRS in support of their monitoring of the stewardship function; and (iii) technical assistance for human resource training in the ARL and the DRS.

2.17 The ISC functions will be conducted in two types of establishments: (i) those serving food to the public (including restaurants, soda fountains and bars); and (ii) health establishments, which will include 9 peripheral hospitals, at least 300 EBAIS, radiology centers, clinical laboratories, hospices, rehabilitation centers, doctors' and dentists' offices and ambulatory surgery and ophthalmological centers.

2.18 The program will finance technical assistance services for the design and execution of monitoring and evaluation activities that will include: (i) compilation of the baseline ISC data in the 32 cantons targeted and in four control cantons with a similar socioeconomic profile; (ii) design of the technical specifications for monitoring and evaluation, with emphasis on devising process and performance indicators for ISC programs; (iii) determining concrete measuring procedures, the techniques to be used, results processing systems, and supporting data processing systems; (iv) defining monitoring and evaluation procedures and instruments; and (v) preparing the technical specifications for the consolidated progress reports and the final report on the ISC pilot project.

2.19 On the basis of program execution, and information produced by the monitoring and evaluation system, technical assistance will be financed for: (i) identifying and consolidating the outcomes and achievements of the pilot program, lessons learned, and policy implications; (ii) up to five regional workshops for presenting the pilot outcomes, (iii) reforms to the existing regulations governing ISC of food and water for human consumption, and of health care establishments, with special priority to those using ionizing radiation equipment; and (iv) preparation of an action plan for extending the stewardship function for ISC to all ARL in the country.

2. Component 2. Institutional strengthening of the CCSS for promoting health (US$1,963,000)

2.20 This component is intended to develop institutional capacities within the CCSS through two subcomponents to be conducted in the 32 beneficiaries cantons: (i) a pilot program of health promotion; and (ii) a pilot program of incentives for innovation in health promotion.

a. Subcomponent 1. The pilot program for health promotion

2.21 The objective of this pilot program is to design, execute and evaluate interventions involving health education and social participation to foster knowledge, attitudes and conduct conducive to health, with special emphasis on (i) promoting healthful lifestyles and (ii) promoting mental health. The CCSS will supplement program activities with its own resources by undertaking social marketing activities in these same priority health areas. In areas where the epidemiological profile so warrants, the program will be supplemented with activities to promote reproductive health and homecare.

2.22 Program interventions will include promotion among individuals and families, and group and community-based advisory services on appropriate physical activity, healthful eating habits and the avoidance of tobacco, alcohol and other drugs, with special emphasis on priority groups, according to the epidemiological profile of each beneficiary canton. The priority groups, as agreed between the Bank and executing agency, are (i) women, (ii) children and adolescents, (iii) the elderly and (iv) indigenous communities.

2.23 The health education interventions will involve at least 100 pilot projects in the 32 beneficiary cantons, and will cover approximately 350,000 CCSS affiliates. The pilot projects may be conducted in homes, in the workplace or in recreation areas, as well as in the schools, and may be extended to other social and community facilities. At least two pilot projects will be conducted in each of the four cantons where there are indigenous reserves, using special, culturally adapted measures that will include the incorporation of traditional knowledge, indigenous medicine, and the participation of traditional indigenous medical practitioners. These measures will be based on an anthropological and epidemiological evaluation conducted in advance of implementation.

2.24 To achieve the program objectives, this component will involve the activities described below.

2.25 **Standardizing methods and materials**. The program will finance technical assistance for the design and execution of a standardized methodology for producing health education services and social participation for promoting healthful lifestyles. The sub-activities to be conducted will include technical assistance for: (i) reviewing the state-of-the-art in health promotion in countries at a similar level of development; (ii) preparing and systematizing model interventions for health education and social participation; (iii) quantitative and qualitative studies to identify the factors determining unhealthy attitudes and practices among the program's target groups; (iv) preparation of a health promotion plan following the new methodologies in the 32 beneficiary cantons; (v) promotion and dissemination of the plan; and (vi) human resource training in the 32 cantons.

2.26 **Reviewing the state-of-the-art in health promotion in countries at a similar level of development**. The program will finance technical assistance and training services for empirical evaluation of the state of progress of health promotion in Costa Rica. It will also pay for: (i) technical assistance to bring to the country health promotion experts from countries at a similar level of development; and (ii) at least three observation visits to explore health promotion experience in such countries. The lessons learned from these activities, and their implications for the CCSS, will be consolidated into a final report that will be disseminated at all levels of the CCSS.

2.27 **Monitoring and evaluation system**. The program will finance technical assistance for the following activities: (i) constructing a baseline for health promotion in the 32 beneficiary cantons; (ii) description and recording of monitoring and evaluation systems in use at the beginning of the program; (iii) a survey of health promotion service quality and user satisfaction; (iv) design of technical specifications for the monitoring and evaluation system, with emphasis on constructing process and outcome indicators for the health education and community participation programs; (v) operational definition of measuring procedures, techniques to be used, systems for processing outcomes and computerized support systems; (vi) definition of procedures and instruments for monitoring and evaluation; and (vii) definition of technical specifications for presenting consolidated progress reports for the pilot project on the CCSS web page.

2.28 Program evaluation will be based on designs for measuring people's knowledge, attitudes and practices before, during and after the interventions. This will be done using a baseline or nationally representative entry profile. The analysis of outcomes from the health promotion programs will be based on comparing knowledge, attitudes and habits between target groups and the respective control groups.

2.29 Based on evaluation of the monitoring system, technical assistance will also be provided for: (i) identifying outcomes and successes from the health promotion pilot program; (ii) preparing adjustments to the comprehensive CCSS health model, in particular to the PASP goals and indicators; (iii) proposals for extending the health promotion strategy to all cantons in the country; and (iv) proposals for adjusting the PASP in terms of goals and indicators for health promotion interventions, with particular emphasis on identifying expected outcomes for the program's target groups: women, children, the elderly and indigenous people.

2.30 **Implementing the pilot program**. To implement the new health promotion methodologies, the program will finance: (i) technical assistance to support the Regional Directorates of the CCSS in monitoring health promotion interventions; (ii) technical assistance in support of the Health Areas and the EBAIS in the 32 cantons targeted during the pilot health promotion program, with respect to implementing health promotion activities; (iii) preparation of educational materials; (iv) procurement of exercise and domestic equipment; and (v) education workshops on health and community participation for promoting healthful lifestyles.

2.31 **Dissemination of results and lessons**. The program will finance technical assistance and the production of materials for disseminating the results of the pilot health promotion program through: (i) dissemination workshops in the 32 beneficiary cantons; (ii) a national seminar to present the results; and (iii) publication of those results.

2.32 **Estimating the financial sustainability of the health promotion strategy**. The program will finance specialized consulting services to construct a financial and

economic model for projecting costs, social benefits and the effectiveness of extending the pilot health promotion program to the entire country, and to recommend mechanisms to the CCSS for enhancing the financial feasibility of such an extension, under various macroeconomic and fiscal scenarios.

b. Subcomponent 2. Pilot program of incentives for innovation in health promotion

2.33 This subcomponent is intended to encourage innovation in the design and implementation of health promotion programs in the beneficiary cantons. It will involve the activities described below.

2.34 **Strategic partnerships**. The program will finance the following activities: (i) technical assistance for the design of at least 20 pilot health promotion programs involving strategic partnerships between the CCSS and (a) community agencies and associations, (b) the private sector and/or (c) municipalities, for promoting appropriate physical activity and healthful eating habits; (ii) procurement of exercise and gymnast equipment; and (iii) production of supporting educational materials.

2.35 **Prizes for innovation in health promotion**. The program will finance technical assistance for the design and execution of a program of prizes for the five most innovative projects in health promotion that have been implemented and evaluated during program execution in the areas of: (i) promoting physical activity among the elderly; (ii) promoting healthful eating habits among girls and/or women; (iii) anti-smoking campaigns aimed at teenagers; (iv) promoting health in an indigenous community; and (v) promoting a culture of peaceful coexistence. After 30 months of program execution, a committee consisting of the Executive President, the Medical Division Manager, and the Health Promotion Coordinator will propose the winning teams to the Bank, based on a technical evaluation of the results achieved. In all cases and for all projects, the prize will consist of an international training fellowship in health promotion, funded by the program, for up to 15 days in a Bank member country at a similar level of development.

2.36 **Disseminating outcomes and lessons from the program**. The program will finance technical assistance and the production of materials for disseminating the outcomes from the pilot project for innovation incentives in health promotion, through: (i) preparing a document compiling prize-winning experiments under this subcomponent; (ii) a national seminar to present the results and the document; and (iii) publication of the results.

C. Program costs

2.37 The total cost of the program has been estimated US$8 million, broken down as follows: (i) US$6.3 million from the Bank's Ordinary Capital, in U.S. dollars;

(ii) US$1.7 million in counterpart funding to be covered by the Government of Costa Rica through budgetary allocations to the MS, and by the CCSS from its own resources. The program also provides funding for annual external audits (US$100,000). The finance charges will be paid directly to the Bank by the borrower. Table II.2 shows the costs of the program.

Table II.2
Costs per component and expenditure category (in US$000)

Category of expenditure	IDB	GCR	TOT	%
1. Strengthening the stewardship function (MS)	4,010	1,172	5,181	64
1.1 Steering in the health sector				
1.1.1 Generating empirical evidence	771	24	795	
1.1.2 Developing advocacy and information capacities	98	25	123	
1.2. Inspection, supervision and control				
1.2.1 Regulatory and legal framework for the stewardship function	113	15	128	
1.2.2 Developing capacities at the central level	1,228	136	1.364	
1.2.3 Institutional strengthening at the decentralized level	1,800	972	2,771	
2. Health promotion (CCSS)	1,569	393	1,963	24
2.1. Pilot health promotion project	1,055	264	1,319	
2.2. Incentives to health promotion				
2.2.1 Strategic alliances program	378	95	473	
2.2.2 National innovation prize	52	13	65	
2.2.3 Dissemination of results	84	21	106	
3. Support for program execution	612	153	765	9
3.1 Support to the MS	325	82	407	
3.2 Support to the CCSS	287	71	358	
4. Financial audit	100		100	1
4.1 In the MS	50		50	
4.2 In the CCSS	50		50	
5. Finance charges	64		64	1
5.3 Inspection and supervision	64		64	
TOTAL	**6,355**	**1,718**	**8,073**	**100**
Percentages	79	21	100	

III. PROGRAM EXECUTION

A. Institutional structure

3.1 The borrower will be the Republic of Costa Rica. The executing entities will be the Ministry of Health (MS) and the Costa Rican Social Security Fund (CCSS).

3.2 The MS will be responsible for execution of activities under component 1, while CCSS will have responsibility for component 2. Each of these institutions will be responsible to the Bank for: (i) supervision, quality control and monitoring of specific activities; (ii) administration of financial resources; (iii) procurement of works, goods and related services, and consulting services; (iv) submitting disbursement requests to the Bank; and (v) preparing and submiting timely progress reports to the Bank.

3.3 Given the program's innovative and experimental nature, it will be essential to ensure that outcomes are appropriated and internalized as promptly and completely as possible, and the MS and the CCSS will therefore execute the program through their own organizational structures.

3.4 Within the MS, the Office of the Vice Minister of Health will have primary responsibility for program execution, and will be supported by the Directorate of Health Development, the Directorate of Health Services and the Directorate of Human Environment Protection. The Directorate of Health Development is the unit responsible for coordinating externally financed projects and programs. A staff professional of this directorate will be assigned full-time as Technical Coordinator of the Program, with primary responsibility for monitoring execution. Specific activities under component 1 will be carried out by staff officers of the Directorate of Health Services and the Directorate of Human Environment Protection. The evaluation of the ministry's institutional capacity for program execution indicated the need for strengthening in the areas of procurement and financial accounting, and long-term consulting services will be contracted for this purpose with funds from the loan.

3.5 In the case of the CCSS, execution will be in the hands of the Medical Management Unit. This Unit has the experience and capacity needed to implement externally financed programs and projects, for which reason plans call only for contracting a Program Technical Coordinator, as a charge to the loan, to coordinate the various activities.

3.6 The coordination and consultation body for the health sector is the National Health Council, composed of the Minister or, in her absence, the Deputy Minister of Health, acting as chair the Executive President of the CCSS, the Executive President of the Costa Rican Water and Sewage Institute (AYA), the Director for

Health, the Manager of the Medical Division of the CCSS, the Director of Health Development, and a representative of the Ministry of Planning, a representative of the University of Costa Rica in Health Sciences, and a representative of professional associations of health sciences. The Council will serve as the coordination body for the program, in order to: (i) analyze progress and outcomes from the program, and its contribution to sectoral policy; and (ii) evaluate the functioning of the coordination mechanisms and instruments established within the ministry and the CCSS for purposes of the program.

B. Execution plan

3.7 The program will be executed over a period of 30 months, and the disbursement period will be 30 months, except for the funds earmarked for the final evaluation, for which the disbursement term will be six months longer. Execution will proceed in accordance with operational, technical and financial requirements. The execution plan includes a flexible mechanism combining the following elements: (i) preparation and implementation of the Program Execution Plan (PEP) which includes the sequence of activities and sub-activities, anticipated execution times, and the persons responsible for PEP implementation; (ii) a Program Performance Plan (PDP), which includes indicators of progress and expected outcomes, with their respective means of verification; and (iii) semi-annual technical reviews by the Bank, during which any required adjustments can be made to the PEP, and the progress of the program and its process and outcome indicators can be constantly monitored.

3.8 Within the MS, the **Directorate of Health Development** will be responsible for: (i) monitoring compliance with component 1 objectives; (ii) preparing and submitting to the Bank periodic progress reports, including financial reports, on a timely basis; (iii) maintaining financial accounts that will identify the source and use of funds, as well as internal control procedures; (iv) bidding and contracting for minor works, and procurement of goods and related services, and consulting services; (v) preparation of terms of reference for audits and (vi) administration of financial resources and authorization of payments to suppliers of goods and services.

3.9 This unit will be responsible for preparing terms of reference and identifying and selecting individual consultants or firms for: (i) studies; (ii) technical assistance for the development of instruments and production of materials; (iii) training for human resources within the ministry's head office, the regional offices and the ARL; (iv) and producing materials related to subcomponent 1. It will prepare the plan for basic improvements and maintenance of physical infrastructure of the ARL and will contract the rehabilitation and maintenance services required by that plan. It will also (i) conduct dissemination workshops for the results, (ii) organize a national seminar for presenting the policy instruments, and (iii) publish the instruments and results.

3.10 The **Health Services Directorate** will be responsible for preparing terms of reference and identifying and selecting individual consultants or firms for: (i) studies; (ii) technical assistance for development of instruments and production of materials; (iii) training for human resources of the Directorate, the regional offices, and the ARL at the local level; and (iv) producing materials relating to the ISC and licensing of health care establishments. It will also (i) conduct the five regional workshops for disseminating results from the pilot project for authorizing health care establishments; (ii) conduct the national seminar; and (iii) adapt existing regulations for the inspection, supervision and control of health care establishments.

3.11 It will also: (i) formulate and implement a methodology for monitoring and evaluating activities under subcomponent 2, with respect to the licensing and ISC of health care establishments; (ii) present progress reports on the program to the Health Development Directorate; and (iii) participate in observation visits to countries at similar levels of development.

3.12 The **Human Environment Protection Directorate** will be responsible for preparing terms of reference and contracting for: (i) studies; (ii) technical assistance for the design of methodology for ISC of food and drinking water and the design and implementation of an information system; (iii) training for personnel of the directorate, the regional offices and the local ARL; and (iv) producing educational materials under subcomponent 2. It will conduct consultation and dissemination workshops on the outcome with representatives of the various sectors in the 32 beneficiary cantons, and will carry out the pilot projects for testing ISC methodologies for water and food. It will also carry out five regional workshops to present the findings of the ISC pilot projects, as well as the pilot project for training food handlers. It will participate in observation visits to countries at similar levels of development, and will evaluate the pilot projects and disseminate their results through five regional workshops and a national workshop.

3.13 It will also prepare the procurement plan and will support the purchase of office equipment, computers and basic analytical tools, and it will prepare the action plan for extending the stewardship function for the ISC of water and food to all ARL in the country.

3.14 The **Medical Management Unit of the CCSS** will be responsible for: (i) preparing terms of reference and contracting technical assistance under component 2; (ii) procurement of goods and production of educational materials for health promotion in the communities; (iii) administering the program of health promotion incentives; and (iv) participating in visits to observe health promotion activities in countries at similar levels of development.

3.15 It will also be responsible for: (i) monitoring achievement of objectives under component 2; (ii) preparing and delivering to the Bank periodic progress reports, including financial reports; (iii) maintaining financial accounts that will identify the

source and use of funds, as well as internal control procedures; (iv) bidding and contracting for the procurement of goods and related services, and consulting services; (v) preparation of terms of reference for annual audits; (vi) administration of financial resources and authorization of payments to suppliers of goods and services.

C. Procurement

3.16 International competitive bidding will be required for goods and related services in amounts above US$250,000 and for consulting services in amounts above US$200,000. Contracts for the construction of works under the program will be covered by the local counterpart and will be subject to Bank procedures, according to which competitive bidding will be required for contracts in amounts above US$1 million, although it may be limited to local competitive bidding.

D. Disbursements

3.17 **Revolving fund**. It is recommended that each of the executing entities should be given an advance of the equivalent of 5 percent of the respective component. Each executor will establish a revolving fund, through which loan funds can be disbursed directly to the MS and the CCSS. These institutions will open a separate bank account in the name of the program, for which they will be the authorized disbursement agents; they will also be responsible to the Bank for keeping financial records and accounts as required for proper financial administration of the program, and presenting disbursement applications, reports and financial statements as required by the Bank. The counterpart resources will be deposited in separate accounts by each executing agency, and records will be kept for verifying annual allocations and expenditures of those funds.

3.18 **Recognition of expenses**. For each of the executing agencies an amount of up to US$50,000 may be charged to the local contribution in recognition of expenditures made by the CCSS or the MS, during the 18 months preceding approval of the loan, but subsequent to 21 June 2002, for preparatory technical assistance and early startup of operations, provided such expenditures comply with Bank procedures. Eligible activities include the contracting of consultants to prepare terms of reference, bidding documents, the startup workshop, and the necessary adjustments to the legal framework and execution plan.

3.19 **Disbursement schedule**. The tentative disbursements schedule for the program is as follows:

Year 1	Year 2	Year 3
35%	40%	25%

E. Accounts and audits

3.20 The MS and the CCSS will maintain separate accounts and records for proceeds of the loan and the local counterpart contribution, in accordance with generally accepted principles, and will establish independent internal control mechanisms to ensure compliance with the program's operating rules. Accounting and audit procedures will be consistent with Bank policies (AF-100 and AF-300).

3.21 The MS, in consultation with the CCSS, will use program funds to hire a firm of external auditors acceptable to the Bank, in accordance with terms of reference agreed with the Bank, to conduct the annual program audit. The audit will cover, among other things: (i) the use of resources from the two revolving funds; (ii) a sample-based examination of disbursement applications; (iii) a sample-based examination of documentation on the procurement and contracting of works, goods and related services, and consulting services; (iv) an evaluation of the accounting and internal control system; and (v) an evaluation of compliance with the terms and conditions established in the loan contract. This report will be submitted no later than 120 days after the end of the fiscal year of the executing agencies. The same firm of auditors will conduct the audit of both institutions.

F. Contractual conditions

3.22 Signature of an agreement for transferring funds between the Ministry of Finance and the CCSS will be a condition precedent to the first disbursement of component 2. This agreement will stipulate the terms and conditions at which the government will transfer the proceeds of the financing, and the execution obligations of CCSS as stipulated in the loan contract.

3.23 Prior to distribution of this document the regulations governing the Ministry of Health entered into force, establishing, among other aspects, the jurisdiction and responsibilities of the DRS and the ARL as they relate to the decentralized exercise of the stewardship function.

G. Monitoring and supervision

3.24 The Bank will monitor the program through its Country Office in Costa Rica (COF/CCR). Social Programs Division 2 will support the COF/CCR in all technical aspects that require special attention.

3.25 The Bank will conduct semi-annual technical reviews to analyze: (i) the state of progress with program execution during the immediately preceding six months, in terms of the activities and indicators agreed in the PEP and the PDP; (ii) dissemination and learning mechanisms in place; (iii) coordination mechanisms; and (iv) annual investment plans. Based on the findings of these technical reviews, the Bank may request (a) adjustments to the operations plan, including changes in

the execution and performance plans for the program; (b) cancel components; or (c) increase the scale of the pilot projects or suspend them.

3.26 Progress with the operations plan will be monitored on a semi-annual basis, using the Project Performance Monitoring Report (PPMR) prepared for the operation.

1. Startup workshop

3.27 A startup workshop for the program will be organized by the borrower, with the support of the Bank, no later than three months after the operation is declared eligible. That workshop will involve the stewardship teams from the MS (central office, DRS, ARL) and the CCSS (central office, health areas and EBAIS). This activity will be financed from the Bank's loan, and will include the contracting of a specialized consultant.

2. Mid-term evaluation

3.28 Once 50 percent of loan resources has been disbursed, or 15 months after the loan contract comes into effect, the Bank will conduct an interim evaluation, based on the PPMR, which will include an in-depth review of the semi-annual technical evaluations. This activity will be financed from the Bank loan and will include the contracting of a specialized consultant by the MS, in consultation with the CCSS.

3. Final evaluation

3.29 Upon completion of program execution, but before the final disbursement, the executing agencies will hire a specialized consultant to conduct a final evaluation of program execution, achievements and lessons learned. That consultant will consider the lessons learned through the program's monitoring, evaluation and learning system. This activity will be financed from the Bank loan and will include the contracting of a specialized consultant by the MS, in consultation with the CCSS.

IV. FEASIBILITY AND RISKS

A. Institutional feasibility

4.1 The project team conducted an institutional feasibility analysis for execution of the program, identifying the critical institutional elements that would ensure program feasibility: (i) the existence of clear institutional roles and responsibilities in the two executing agencies; and (ii) execution of the program within the organizational structure of the two agencies themselves.

4.2 One of the major achievements of the health sector reform in Costa Rica has been to produce a clear definition and separation of roles and responsibilities for the MS and the CCSS. This has reduced the duplication of functions and facilitated coordination within the health sector, while reducing the potential for inter-institutional conflict. The team obtained evidence that the institutional coordination mechanism created by the Health Act, the National Health Sector Council, has been implemented. Not only does the Council meet frequently, but its composition allows for the taking of decisions and implementation of policies affecting the entire sector. This is considered an institutional strength that will facilitate achievement of the program's objectives.

4.3 The team assessed the experience of each of the two executing agencies in handling internationally financed projects, and found that both agencies have such experience, but that it has been acquired through the mechanism of executing units. Given the program's innovative nature and the moderate scale of institutional demands that it would impose on the two agencies, executing the program within the existing organizational structure would produce significant learning experience and contribute to their institutional development.

4.4 Finally, program execution is based on a model that involves participation, information and consultation, consistent with the gradualist and consensus-based approach that Costa Rican society has taken so far in reforming the health sector. Apart from enhancing the program's social and political feasibility, the use of modern tools of participation, consultation and information should create new institutional capacities, particularly within the MS, while reinforcing democratization of the process of the formulating, implementing and evaluating public policies.

B. Financial feasibility

4.5 The present program will cost less than 0.1 percent of public health expenditure. The cost of the component for which the MS is responsible, and the required counterpart, represent 5 percent and 1 percent, respectively, of total spending by the MS in 2001; the cost of the CCSS component represents 0.3 percent of CCSS

spending on health care in 2001. The recurrent costs for implementing the program represent additional costs and are insignificant when compared to the overall budget of the MS and the CCSS.

4.6 The Government of Costa Rica, represented by the MS, the CCSS and the Ministry of Finance, has accorded the program high priority, as a fundamental element of the sector's institutional transformation. It is expected that the required counterpart resources will be allocated in a timely manner by both the MS and the CCSS, noting that they represent a very small portion of both institutions' expenditures.

4.7 The MS has made significant efforts to establish mechanisms for improving its financial administration and generating its own revenues from the services it provides. Recently (May 2002), the MS established a trust fund with the Central Bank of Costa Rica. The resources of that trust fund will be used by the MS to fulfill the objectives of the Health Act and to improve its programs and activities. One of the sources of the trust fund, in fact, consists of charges for the ISC services that are to be developed and strengthened by the present program.

C. Environmental and social feasibility

4.8 The program is expected to have a positive social and environmental impact, to the extent that it will create capacities for protecting public health and will contribute to the accumulation of human capital. In addition, the program will assess efforts to consolidate structural reforms of the state, and is consistent with strategic priorities for reducing poverty as part of the government's national development plan.

4.9 The principal environmental benefits of the program will come from strengthening the capacities of the MS to regulate the basic requirements for establishments providing low to moderate-risk health care services. In particular, the program will reduce the environmental risks of institutions using ionizing radiation, by producing and introducing biological safety standards and rules for handling radioactive wastes.

4.10 Apart from execution of the ISC activities and the licensing of these establishments, experience obtained under the program will be used during execution to adapt or improve existing legal rules, before they are extended to the country as a whole.

4.11 Classification as social-equity-enhancing and poverty-targeted. The project spells out explicit performance indicators for measuring poverty reduction and improvements in social equity (see Table II.1). In terms of its poverty reduction impact, the project has been targeted, based on ex ante selection, at beneficiaries in the country's 32 poorest cantons and therefore qualifies as a poverty-targeted investment based on the program sector and the geographic location and proportion of the poor of the beneficiaries.

D. Benefits

4.12 The program will produce several significant social benefits. The first will be in the form of proven tools for improving the regulation, inspection, supervision and control of public health risk factors. These tools constitute national public goods, which will generate social benefits during the program execution period and, more importantly, after execution is completed. Examples of such benefits include: (i) reducing the global burden of disease from microbiological water pollution and improper sanitation conditions for the handling of food; (ii) promoting a culture for reducing and controlling environmental and consumption risks based on public information campaigns; and (iii) making the public food services sector more competitive, to the benefit of the tourism and hotel industry.

4.13 The principal direct benefit of the program in terms of promoting health will be to instill healthful habits and behavior among a significant portion of the poorest and most vulnerable population groups. The number of direct beneficiaries is estimated at 350,000 individuals, while indirect beneficiaries will amount to some 1.2 million in the 32 priority cantons selected on the basis of the poverty incidence and concentration. Direct beneficiaries are considered to be those participating in the education activities under component 2. Nevertheless, the program will have important externalities because of the linkage between the pilot programs for health promotion and the social marketing strategies that the CCSS will finance with counterpart funds. Empirical evidence in other countries suggests that the combination of these three tools for health promotion (education, participation and social marketing) is more effective than employing them in isolation.

4.14 Health promotion activities will contribute to the development of human and social capital over the medium term, and to reducing the burden of preventable disease and disabilities over the longer term. Moreover, the resulting institutional experience and empirical evidence on the costs and benefits of health promotion activities will provide the CCSS with a proven model for health promotion which, if extended to the entire country, will enhance the efficiency of public health expenditure.

4.15 The program will also have a significant positive impact on the health of poor women and indigenous people in Costa Rica. These two vulnerable groups will benefit directly from the health promotion programs that are designed to fit the epidemiological and demographic profile of poor women and indigenous people[5]. Indirectly, the generation of data on the gender distribution of health expenditure and the impact of that expenditure on the health status of women and indigenous people will give the government, and Costa Rican society at large, useful information for making the health system more inclusive and equitable.

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[5] Of the 32 beneficiaries cantons, 4 are home to the majority of the country's indigenous population.

E. Risks

4.16 One risk to program execution lies in the possible resistance to introduction of a regulatory system on the part of public and private health care providers. To reduce this risk, the program includes funding for information and training for the economic agents that will be covered by ISC.

4.17 Another factor that could delay program execution has to do with the time-consuming process of procurement and contracting in Costa Rica. To address this risk, the Bank worked with the executing agencies, during the design of the program, to develop a number of execution and performance plans for scheduling the procurement of goods and the contracting of services, identifying in advance the type of procurement that will be required, and establishing realistic execution time frames. On this basis, the activities included in the program are those with the greatest likelihood of being executed within the established time limits.

LOGICAL FRAMEWORK
HEALTH SECTOR DEVELOPMENT

Narrative Summary	Performance Indicators	Means of Verification	Major Assumptions
Goal 1. To reduce the burden of disease and disability caused by unhealthful lifestyle and consumption factors.	1.1 Years of life lost through poor health habits reduced by 5% compared to the baseline for 2004. 1.2 At least 10% of MS revenues derived from fees and licenses issued in the course of its stewardship functions. 1.3 By December 2009, the share of the CCSS provision-function budget devoted to health promotion and disease prevention has grown by 5% in real terms from its level of January 2003.	1.1.1 Disease Burden System 1.1.2 System of national health accounts 1.1.3 Annual reports by MS and CCSS	**Sustainability** a. The MS reforms its structure and organizational procedures and focuses its activities on the stewardship function and on promoting healthful policies by other institutional players. b. The CCSS universalizes comprehensive health services, including promotion, prevention, care and rehabilitation.
Purpose 1. The GCR decides, on the basis of experience and lessons learned from the program: (i) in the case of the MS, to extend health-risk regulation, inspection, supervision and control to the entire country and (ii) for the CCSS, to extend comprehensive health care programs based on health promotion and disease prevention to all EBAIS in the country.	1.1 ISC covering consumption risk factors (water and food) operating in 100% of health areas. 1.2 Health promotion and disease prevention programs operating in at least 90% of EBAIS in the country.	1.1.1 Final evaluation report 1.1.2 National health policy documents 1.1.3 Annual reports of MS and CCSS	**Purpose to Goal** a. The MS is effective and efficient in its stewardship function, thanks to its technical and human capacities and the policy instruments developed through this program. b. The CCSS integrates health promotion and disease prevention into its service model and is able therefore to respond efficiently and effectively to the country's epidemiological profile.

Narrative Summary	Performance Indicators	Means of Verification	Major Assumptions
Components			**Components to Purpose**
1. Institutional capacities of the MS to design, implement and evaluate decentralized policy instruments for initial execution of the stewardship function developed, implemented and evaluated.	1.1 Thirty-two local stewardship areas conducting ISC on food and drinking water and on health service establishments, with priority to those using ionizing radiation equipment, by the end of the execution period.	Reports from the monitoring and evaluation system	a. The MS decides to extend the decentralized inspection, supervision and control functions to all health areas as proposed in this program.
	1.2 Risk and critical control point analysis methodologies in place and evaluated, with lessons assimilated, by the end of program execution.	Rules and procedures published	
	1.3 Four health policy instruments for defining health priorities, financing and expenditure published and disseminated by end of first year of execution.	Final reports on the four policy instruments	
	1.4 Legal rules for the stewardship function updated by the end of execution.	Interim program evaluation	
	1.5 Proposed reforms to the Health Act submitted by the Executive to the Legislative Assembly by end of execution period.	Order approving entry into force of the legal framework and technical standards Order submitting the proposal to the Assembly	
2. Institutional capacities of the CCSS to design, test and evaluate programs of health promotion and disease prevention developed, implemented and evaluated.	2.1 At least 100 pilot health promotion projects executed and evaluated by end of execution period.	Reports of the monitoring and evaluation system	a. CCSS beneficiaries and affiliates, its Governing Board, and interest groups within the organization support nationwide dissemination and extension of health promotion and disease prevention programs tested in the pilot projects under this program.

Narrative Summary	Performance Indicators	Means of Verification	Major Assumptions
	2.2 At least 350.000 CCSS affiliates have received healthy lifestyle education by end of execution period.	Assessment survey of CCSS services	
	2.3 At least 10 pilot health promotion projects designed, executed and evaluated through strategic partnerships with community agencies, municipalities and/or the private sector.	Reports from the monitoring and evaluation system	
	2.4 Individual Health Care Plan updated so that its health promotion goals and indicators reflect lessons learned from the program.	Order approving and implementing the Plan for the ARLs	
	2.5 Technical standards for execution and supervision of health promotion programs updated.	Order establishing the technical standards	
Activities	**Budget US$**		**Activities to Components**
Component 1			
1.1 Generate empirical evidence for sector steering	795,000	Progress reports Technical assistance reports approved	The country has the required technical know-how to prepare policy instruments.
1.2 Develop public advocacy and information capacities	123,000	Books published Reports published	The health authorities are interested and prepared to consult with other ministries, with civil society and with social players targeted by ISC.
1.3 Legal and regulatory framework for the stewardship function	128,000	Newspaper stories Internet sites and/or intranet functioning	Communities in the thirty-two cantons are interested in participating in consultation and information activities for ISC.
1.4 Develop ISC capacities in the MS at the central level	1,364,000	Monitoring and evaluation reports	Officials in the decentralized services are interested in acquiring and applying IFC methodologies and instruments.
1.5 Institutional strengthening in ISC at the decentralized level of the MS	2,772,000		

Narrative Summary	Performance Indicators	Means of Verification	Major Assumptions
Component 2			
1.1 Pilot project in health promotion	1,319,000	Progress reports	The health authorities within CCSS are interested and prepared to implement pilot health promotion programs based on a quasi-experimental evaluation design.
1.2 Strategic partnerships program	473,000	Technical assistance reports approved	Communities in the thirty-two cantons are interested in participating in health promotion activities.
1.3 National innovation prize	65,000	Newspaper stories	Officials in the EBAIS and Health Areas of the CCSS are interested in acquiring and applying health promotion methodologies and instruments.
1.4 Dissemination of results	105,000	Internet sites and/or intranet functioning. Monitoring and evaluation reports	

PROCUREMENT PLAN
HEALTH SECTOR DEVELOPMENT

Principal procurement items	Financing	Bidding method (US$)	Pre-qualification	Date planned for SPN publication
1. Program administration				
Long-term consulting contracts to support execution: US$285,000 1. Technical Coordinator for the CCSS 2. Procurement Specialist for the MS 3. Accounting and Financial Specialist for the MS	100 % IDB	ICB above US$200,000 LCB between US$75,000 and US$200,000 PB below US$75,000	No	I-2003
Short and medium-term consulting services: US$115,000 1. Mid-term Evaluations 2. External Audit	100% IDB	ICB above US$200,000 LCB between US$75,000 and US$200,000 PB below US$75,000	No	II-2004 I-2003
Goods and services: US$186,000 1. Operating expenses for program administration 2. Office equipment and furnishings for program administration	80% IDB 20% GCR	ICB above US$250,000 LCB between US$100,000 and US$250,000 PB below US$100,000	No	I-2003
2. Program execution				
Short and medium-term technical assistance: US$1,730,000 1. Studies to analyze the disease burden 2. Study to develop a system of national health accounts 3. Study to develop a supply and demand model for human resources in the health sector 4. Study to monitor equity and quality of health services at the local level 5. Technical assistance for implementing health policy formulation instruments 6. Comprehensive study of the regulatory and legal framework of the MS 7. Proposed reforms to the legal and regulatory framework for inspection, supervision and control 8. Standardized methodology for risk assessment 9. Design of a pilot project for decentralizing ISC functions for water, food and service provider accreditation 10. Design of an information system for the MS and an implementation plan 11. Installation and operation of the information system for the MS 12. Baseline survey for inspection, supervision and control. 13. Design of a monitoring system for component 1 of the program 14. Technical design of the geo-referenced information system	93% IDB 7% GCR	ICB above US$200,000 LCB between US$75,000 and US$200,000 PB below US$75,000	No	I-2003

Principal procurement items	Financing	Bidding method (US$)	Pre-qualification	Date planned for SPN publication
15. Technical support and training for operating the geo-referenced information system. 16. Financial sustainability model for decentralizing inspection, supervision and control functions. 17. Design of a methodology and master plan for information, consultation and participation. 18. Inventory requirements for rehabilitating and improving ARL and DRS facilities. 19. Design and application of a standardized methodology for the health promotion pilot program. 20. Design of a pilot project for decentralizing health promotion. 21. Baseline survey on health promotion 22. Design of a monitoring system for component 2 of the program. 23. Formulation of an adjustment plan and implementation strategy for the comprehensive health model of the CCSS. 24. Financial sustainability model for the health promotion strategy. 25. Design of community health promotion programs. 26. Preparations for the first national innovation prize in health promotion. 27. Preparation of documentation on health promotion.				
Long-term technical assistance: US$1,980,000 1. Implementation and operation of the monitoring system for component 1 of the program. 2. Technical assistance and support for the 32 ARL and DRS of the program. 3. Implementation and operation of the monitoring system for component 2 of the program. 4. Technical assistance and support for the 32 AS and EBAIS 5. Technical assistance with community health promotion projects. 6. Organizing health promotion events.	80% IDB 20% GCR	ICB above US$200,000 LCB between US$75,000 and US$200,000 PB below US$75,000	No	I-2003
Training: US$1,060,000 1. Organizing the international observation visit. 2. Organizing workshops for the 32 ARL. 3. Organizing the national seminar for the MS. 4. Public consultation and information activities for MS. 5. Training program in ISC for central staff of the Ministry of Health. 6. Training program in statistics and quantitative methods for MS personnel. 7. Organization of consultation workshops for the MS. 8. Training program on the sanitary aspects of food handling. 9. Training program in biological quality and safety. 10. Design and execution of the training plan for the ARL and DRS.	80% IDB 20% GCR	ICB above US$200,000 LCB between US$75,000 and US$200,000 PB below US$75,000	No	I-2003

Principal procurement items	Financing	Bidding method (US$)	Pre-qualification	Date planned for SPN publication
11. Design and implementation of the training plan for the AS and EBAIS. 12. Organization of workshops for AS and EBAIS. 13. Organization of the national health promotion seminar. 14. Organization of a training program for winners of the national innovation prize for health promotion. 15. Organization of training programs for the Program Coordination Unit.				
Computer equipment and software US$560,000 1. Purchase of software for statistics and quantitative methods. 2. Equipment for operating the information system of the MS. 3. Procurement of equipment and software for the Geo-Referenced Information System. 4. Purchase of computer equipment for ARLs and DRS. 5. Computer equipment for program administration.	90% IDB 10% GCR	ICB above US$250,000 LCB between US$100,000 and US$250,000 PB below US$100,000	No	I-2003 to I-2004
Equipment, goods and related services for health promotion: US$940,000 1. Publication of materials. 2. Equipment for analyzing radioisotopes and drinking water samples. 3. Publication and distribution of health promotion materials. 4. Equipping gymnasiums for community health promotion activities. 5. Publication of educational materials for community health promotion programs. 6. Publication of educational materials on health promotion	80% IDB 20% GCR	ICB above US$250,000 LCB between US$100,000 and US$250,000 PB below US$100,000	No	I-2003 to II-2004
Laboratory services $450,000 1. Contracting of laboratory services	80% IDB 20% GCR	ICB	Yes	I-2003
Works: US$635,000 1. Improvements to basic facilities at establishments housing the 32 ARLs	100% GCR	ICB above US$1,000,000 LCB between US$200,000 and US$1,000,000 PB below US$200,000	No	II-2003

ICB International Competitive Bidding
LCB Local Competitive Bidding
PB Private Bidding
SPN Special Procurement Notice